United States Court of Appeals

for the Second Circuit

APPELLEE'S BRIEF

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75-6128

To be argued by
FREDERICK P. SCHAFFER

United States Court of Appeals

B

FOR THE SECOND CIRCUIT

P/S

Docket No. 75-6128

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1968,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

—against—

DAVID MATTHEWS as Secretary of the United States Department of Health Education and Welfare, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants-Appellees.

UNITED STATES COURT OF APPEALS
FILED
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SECOND CIRCUIT

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

BRIEF OF DEFENDANTS-APPELLEES

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Defendants-Appellees.

BRIEF OF DEFENDANTS-APPELLEES

Issues Presented

1. Was the Court below correct in holding that the promulgation of 20 C.F.R. § 405.454(j) by the Secretary of Health, Education, and Welfare, pursuant to his authority under 42 U.S.C. § 1395g, was agency action committed to agency discretion by law and therefore unreviewable under the Administrative Procedure Act, 5 U.S.C. § 701(a)(2)?

2. Was the above-mentioned regulation within the Secretary's authority under 42 U.S.C. § 1395g and consistent with the Medicare reimbursement principles contained in 42 U.S.C. §§ 1395f(b) and 1395x(v)(1)(A)?

3. Was the promulgation of the above-mentioned regulation by the Secretary of Health, Education, and Welfare a valid exercise of his discretion under 42 U.S.C. § 1395g and not arbitrary, capricious, and an abuse of discretion?

Statement of the Case

This action was commenced on November 21, 1975 by plaintiffs-appellants, Greater New York Hospital Association and Peninsula Hospital Center, on behalf of themselves and all other members of the Association who are similarly situated (2a-14a). Their complaint seeks a preliminary and permanent injunction against the implementation of a regulation promulgated by the Secretary of Health, Education, and Welfare (hereinafter "the Secretary"), 20 C.F.R. § 405.454(j), and a declaratory judgment that said regulation was arbitrary, capricious, and an abuse of discretion and otherwise not in accordance with law. Jurisdiction was founded on 28 U.S.C. §§ 1331 and 1361 and relief was sought under the Administrative Procedure Act (hereinafter "the APA"), 5 U.S.C. §§ 701 *et seq.*, and the Declaratory Judgment Act, 28 U.S.C. § 2201. On the same day, the District Court issued a temporary restraining order enjoining the implementation of the challenged regulation (19a-21a).

On November 28, 1975 a hearing was held on the application of plaintiffs-appellants for a preliminary injunction, at the conclusion of which the Court extended the temporary restraining order until December 11, 1975 (277a). Subsequent to the hearing, the parties agreed to consolidate the hearing on the preliminary injunction

with the trial on the merits pursuant to Rule 65(a)(2) of the Federal Rules of Civil Procedure.

On December 3, 1975 twenty-five additional hospitals, not members of the plaintiff class, moved to intervene. That motion was granted without opposition on the condition that the determination of the preliminary injunction motion would be binding on the intervenors without any further evidence being adduced (301a).

On December 11, 1975 the District Court filed an opinion and order dismissing the complaint on the ground that the challenged regulation was not subject to judicial review (311a-22a). On December 12, 1975, plaintiffs-appellants filed their notice of appeal, and on December 29, 1975 intervenor plaintiffs-appellants filed their notice of appeal (323a-29a).

On December 12, 1975 plaintiffs-appellants also filed with this Court a motion for a stay pending appeal, and on the same day the District Court entered an order that defendants-appellees be stayed from implementing the challenged regulation until December 23, 1975 when said motion could be heard by this Court. Pursuant to discussions between the attorneys for the respective parties, an expedited appeal schedule was agreed to, and by letter dated December 17, 1975, Frederick P. Schaffer, the Assistant United States Attorney in charge of this case, informed counsel for plaintiffs-appellants that the challenged regulation would not be implemented with respect to plaintiffs-appellants and intervenor plaintiffs-appellants pending the hearing and issuance of an opinion by this Court. In consideration for this letter, plaintiffs-appellants filed on December 19, 1975 a stipulation withdrawing their motion for a stay pending appeal.

Facts

When the Medicare program first became operational in 1966, it adopted as its interim payment system the conventional method by which health care facilities were reimbursed by health insurance programs. Under this system (hereinafter "conventional reimbursement"), providers of medical services are required to submit to the insurer a billing form on which are itemized the services furnished the patient on whose behalf reimbursement would be made and the providers' charges for these services. Upon receipt of these itemized billings, the insurer processes them and then sends out payments to the providers (195a).

It soon became apparent, however, that due to the size, newness, and complexity of the Medicare program, there developed delays not only between the hospitals' furnishing of services to Medicare beneficiaries and their preparation of Medicare billing forms, but also between their submittal of these billings to their Medicare intermediary * and the intermediary's processing of these bills through to payment. To help alleviate this problem, the Medicare program in 1968 administratively introduced and made available to hospitals, for in-patient services only, a method of interim reimbursement which disbursed level amounts of payment at set intervals based on a projection of estimated costs. This method permitted payments to be disbursed prior to the receipt of billing forms and thus by its design increased the predictability of cash flow to hospitals, since payments were made without regard to the clerical action of the hospitals and

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* 42 U.S.C. § 1395h authorizes the use of private organizations, such as the traditional health insurance companies, to facilitate payment to providers of services. All but one of the hospitals in this case have elected to use The Blue Cross Association, more specifically Blue Cross/Blue Shield of New York, as their intermediary.

intermediaries. The system was known as Periodic Interim Payments or PIP. This original PIP system (hereinafter "old PIP") provided for payments on either a weekly or bi-weekly basis, although most hospitals opted for weekly payments. Of the approximate 6,700 hospitals participating in the Medicare program at that time, only about 800 elected to use this method as of January 1973.* The other hospitals participating in Medicare chose to remain on the conventional method of submitting bills and receiving payment after the bills were processed (195a-99a).

On January 29, 1973 a moratorium was placed on conversion of hospitals to the old PIP system until July 1, 1973 in order to conduct a review of the system; in June, 1973 that moratorium was extended until further notice pending completion of the review (199a-200a; 297a-300a). The review of the old PIP system which was conducted during the moratorium period was necessary in order to determine whether its weekly payment schedule was equitable and necessary (201a). As a result of the review, it was determined that weekly payments generated reimbursement almost concurrently with the

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* On p. 7 of their Brief, plaintiffs-appellants claim that over 95% of the Medicare payments in New York City are made under the old PIP system, citing to the testimony of Mr. Jansak (274a). This citation does not support that claim and is completely misleading. As a reading of Mr. Jansak's testimony will show, he first misunderstood the question of plaintiffs' counsel and then, realizing his error, stated he did not know what percentage of the Medicare payments to New York City hospitals are made under old PIP (274a-75a).

Similarly misleading is the claim on p. 7 that in more than 90% of the "cases", an audit results in retroactive adjustments in favor of the hospitals. Although Mr. Ingram testified that in dollar volume at least 90% of these settlements result in payments to the hospitals, he specifically denied any knowledge as to what percentage of the hospitals received such payments (189a-90a).

furnishing of services and considerably more rapidly than conventional interim reimbursement and that this disbursement in advance of actual expenditure was an overly liberal approach, not required by law or regulations, which unnecessarily deprived the Federal Hospital Insurance Trust Fund, see 42 U.S.C. § 1395i, of interest earnings (202a-07a; 215a-18a).

In September 1973 the moratorium on PIP was lifted, and a modified PIP system (hereinafter "new PIP") was made available to all classes of providers that wished to convert to it. Under new PIP payments cover a two-week rather than a one-week period of service, and such payments are disbursed no earlier than two weeks after the end of the service period (293a-96a). Thus, where old PIP had contained an average 3½ day lag between the delivery of services and the disbursement of payments, under new PIP the average lag was 21 days. The hospitals receiving weekly PIP payments were permitted to remain on the original method.* Between September 1973 and the present, approximately 600 hospitals which had previously been on the conventional reimbursement method elected to switch to the modified PIP method (209a-10a; 293a-96a).

On January 16, 1974 the new PIP system was published as a Notice of Proposed Rulemaking, 39 Fed. Reg. 2011; pursuant to the proposed regulation, all hospitals which were still on old PIP would be required to convert

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* The new PIP system contained a number of other important differences from old PIP which are not in issue here. For the first time skilled nursing facilities and home health agencies were permitted to avail themselves of a periodic interim payment system, and all providers with current financing outstanding were required to repay any such amount in full prior to conversion to new PIP or have such amount recovered by partial offset of the PIP payments (295a).

to new PIP (212a-13a; 291a-92a). In response to that Notice, approximately 70 letters were received. Nearly all were from hospitals or hospital associations, and they generally were critical of the proposed change. These comments were not disregarded or taken lightly. However, the Secretary concluded that the need for greater uniformity in the treatment of providers, the lack of need for payments as frequently as weekly, and the cost to the Federal Hospital Insurance Trust Fund of continuing the old PIP system, outweighed the reasons articulated in the comments which opposed the modified PIP system (214a-18a; 289a).

On July 16, 1975 the final regulation establishing new PIP and abolishing old PIP was promulgated, 40 Fed. Reg. 29815 (288a-89a). Pursuant to the regulation, full conversion to new PIP was to be completed by September 15, 1975. It was immediately realized that compliance with this requirement would have resulted in a cessation of PIP payments to hospitals accustomed to receiving weekly PIP payments for the period August 15, 1975 through September 14, 1975. To lessen the reduced cash flow problem these hospitals would experience if conversion of their PIP payments were fully implemented by September 15, 1975, the Secretary, on September 2, 1975, changed the final implementation date to May 31, 1976, 40 Fed. Reg. 40192 (286a-87a). This date change granted the affected hospitals nine additional months to convert to the new schedule, thus affording them sufficient time to adjust revenues to payroll schedules and to make vendor payments. In mid-October 1975, program instructions for phasing in the new PIP system for hospitals still receiving weekly PIP payments were issued (282a-85a). Under this gradual conversion schedule, weekly PIP payments to the 800 hospitals on the old PIP system continued through November 1975. PIP payments after November 1975

were to be disbursed every other week, and the amount of these payments were to be adjusted, as necessary, to fully implement the new PIP system by May 31, 1976. This schedule has been implemented with respect to all hospitals previously on old PIP except plaintiffs-appellants and the members of the class they represent and intervenor plaintiffs-appellants.

ARGUMENT

POINT I

The Court below was correct in holding that the challenged regulation is not subject to judicial review under the APA.

The Court below held that as long as interim Medicare payments are made at least monthly, the fixing of payment dates is committed to agency discretion by law within the meaning of 5 U.S.C. § 701(a)(2) and therefore not subject to judicial review under the APA (319a). That holding was a correct application of the standards set down by the Supreme Court in *Citizens to Preserve Overton Park* v. *Volpe*, 401 U.S. 402 (1971) and should be affirmed.

Section 10 of the APA, 5 U.S.C. § 701(a)(2) provides that the provisions of the APA concerning judicial review are not applicable to the extent that "agency action is committed to agency discretion by law." In *Citizens to Preserve Overton Park* v. *Volpe*, *supra* at 410, the Supreme Court stated with respect to this exception that:

> "The legislative history of the Administrative Procedure Act indicates that it is applicable in those rare instances where 'statutes are drawn

> in such broad terms that in a given case there is no law to apply.' S. Rep. No. 752, 79th Cong., 1st Sess. 26 (1945)."

At issue in *Overton Park* were two statutes which provided that the Secretary of Transportation "shall not approve any program or project that requires the use of any parkland 'unless (1) there is no feasible and prudent alternative to the use of such land, and (2) such program includes all possible planning to minimize harm to such park . . .' " *Id.* at 411. The Court held that the Secretary's decision was not committed to his discretion and hence unreviewable, for there was clearly "law to apply."* As the Court observed, the language of the statutes "is a plain and explicit bar to the use of federal funds for construction of highways through parks—only the most unusual situations are exempted." *Id.* at 411. Thus, the Court went on to review the Secretary's decision under the standard set forth in 5 U.S.C. § 706(2)(A) by considering "'whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* at 416.

In the instant case, 42 U.S.C. § 1395g provides that "[t]he Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times *as the Secretary believes appropriate* (but not less

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* On page 20 of their Brief, plaintiffs-appellants suggest that it was the legislative intent of the statutes that constituted the "law to apply" in *Overton Park*. If by this plaintiffs-appellants mean that the Supreme Court found "law to apply" based upon the general purpose of the statutes, they are clearly in error. The Court's language at 401 U.S. 402, 411-12, including n. 29 to which plaintiffs-appellants refer, demonstrates that it was the specific standards established by the statutes which enabled the Court to undertake meaningful judicial review, not some vague goal of protecting public parkland.

often than monthly)" (emphasis added). Unlike the statutes in *Overton Park*, the Medicare Act sets forth no factors that the Secretary must consider and whose consideration a court can review. On the contrary, the language "as the Secretary believes appropriate" is completely open-ended. The Court below was therefore correct in concluding that except for the requirement of payments at least monthly, this is precisely a situation where there is "no law to apply" (319a).

The decision of the Court below is quite strongly supported by *East Oakland-Fruitvale Planning Council* v. *Rumsfeld*, 471 F.2d 524 (9th Cir. 1972). In that case, the Court, applying the standards set down in *Overton Park*, held that the decision of the Director of the Office of Economic Opportunity, in reconsidering a program vetoed by a state governor, was unreviewable. Section 242 of the Economic Opportunity Act, 42 U.S.C. § 2834, provides that the Director shall consider whether the vetoed program is "fully consistent with the provisions and in furtherance of the purposes" of the Act. The Court reasoned that it could review the Director's decision only if "this generalized standard somehow takes on a definite and precise meaning that narrowly confines the discretion of the Director." *Id.* at 532. However, after reviewing the legislative history of the Act, the Court concluded:

> "Thus, the standard to be applied by the Director in determining whether to override a governor's veto requires an evaluation of the 'wisdom or desirability' of the particular project as a means to further the purposes of the Act, in light of knowledge, information, and insights contributed by the governor. This standard is extremely general; its application requires the exercise of the Director's expert knowledge regarding the practicality and efficacy of experimental projects. Its generality and breadth are such that it would not afford a

> reviewing court a practicable rule for determining the legality of the Director's ultimate decision to override or not to override. That decision is therefore not subject to judicial review."

Id. at 533. In the instant case there is no need to analyze the legislative history to determine the standard to be applied by the Secretary in determining when interim Medicare payments should be made; the Act specifically states that providers shall be paid at such times "as the Secretary believes appropriate." This "standard" is even more general and broad than that in *East Oakland-Fruitvale Planning Council* v. *Rumsfeld, supra.* It follows a *fortiori* that the Secretary's decision is not subject to judicial review.

This result also finds support in this Court's holding in *Kletschka* v. *Driver*, 411 F.2d 436 (2d Cir. 1969) that the decisions of the Veterans Administration concerning the awarding of research grants are unreviewable. As this Court reasoned there:

> "In the absence of a statute which explicitly precludes judicial review, and we find none here, the extent to which agency action may be scrutinized by the courts depends on an assessment of the need for, and feasibility of, review on the one hand and the possible disruption of the administrative process which might be occasioned by review on the other. See *Cappadora* v. *Celebrezze*, 356 F.2d 1, 5-6 (2d Cir. 1966); *see generally* Saferstein, Nonreviewability: A Functional Analysis of 'Committed to Agency Discretion,' 82 Harv. L. Rev. 367 (1968)."

Id. at 443. Where, as here, there are no standards upon which a court can evaluate the Secretary's decision, judicial review is obviously not feasible.

Plaintiffs-appellants and intervenor plaintiffs-appellants advance a number of arguments to support their position that the Court below erred in holding that the challenged regulation is unreviewable. All of them are without merit.

First, intervenor plaintiffs-appellants rely on this Court's decisions in *Kingsbrook Jewish Medical Center* v. *Richardson*, 486 F.2d 663 (2d Cir. 1973) and *Aquavella* v. *Richardson*, 437 F.2d 397 (2d Cir. 1971). In *Kingsbrook Jewish Medical Center* plaintiff sought a retroactive corrective adjustment of an allegedly inadequate reimbursement under the Medicare program. In *Aquavella* plaintiffs challenged a decision of the Secretary to suspend Medicare payments pending an audit to determine either whether the payments sought were proper or the amount of overpayments that had been made. Since neither of those cases involved the *timing* of interim Medicare payments pursuant to the Secretary's authority under 42 U.S.C. § 1395g, they are completely inapposite to the instant case.

Second, plaintiffs-appellants contend that this case should be governed by the decision in *Barlow* v. *Collins*, 397 U.S. 159 (1970), where the Court held that there is nothing in the language of 16 U.S.C. § 590d(3), granting rulemaking authority to the Secretary of Agriculture, which expressly or impliedly precluded judicial review or committed the challenged action to agency discretion. That case, however is easily distinguishable from the case at bar, since in *Barlow* there was no difficulty in finding law to apply. On the contrary, the regulation there was challenged on the ground that its definition of the phrase "making a crop" conflicted with the definition of that term intended by the statute. The Court placed heavy emphasis on this fact in its decision, reasoning that "since the only or principal dispute relates to the meaning of the statutory term, the controversy must

ultimately be resolved, not on the basis of matters within the special competence of the Secretary, but by judicial application of canons of statutory construction." *Id.* at 166. The instant case, on the other hand, involves a challenge to the Secretary's exercise of authority in an area within his special competence where the statute has granted him broad and undefined discretion.*

Third, plaintiffs-appellants and intervenor plaintiffs-appellants argue that the Court below misapplied *Citizens to Preserve Overton Park* v. *Volpe*, *supra* by requiring a different standard of proof for the exception from judicial review contained in 5 U.S.C. § 701(a)(1) than that contained in § 701(a)(2).** Relying on dictum in *Association of Data Processing Organizations, Inc.* v. *Camp*, 397 U.S. 150, 156 (1970), they contend that the only proper standard for both exceptions is whether the statute gives "clear and convincing evidence" of an intent to preclude judicial review. Since the Court below found that there was no such evidence here (318a), plaintiffs-appellants and intervenor plaintiffs-appellants conclude that judicial review is appropriate in this case. This conclusion is based on a misinterpretation of both *Overton Park* and *Data Processing*.

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* Thus, even if it were true, as plaintiffs-appellants contend, that the language of 16 U.S.C. § 590d(3) is similar to that of 42 U.S.C. § 1395g, it does not follow that *Barlow* is controlling here, because § 590(d)(3) did not provide the law to apply in that case.

** 5 U.S.C. § 701(a) provides in full:

> "(a) This chapter applies, according to the provisions thereof, except to the extent that—
>
> (1) statutes preclude judicial review; or
>
> (2) agency action is committed to agency discretion by law."

In *Overton Park*, *supra*, 401 U.S. at 410, the Supreme Court quite clearly *did* establish different standards for the exceptions created by § 701(a)(1) and § 701(a)(2). With respect to the former, it stated that there must be either a specific statutory prohibition of review or a "'showing of "clear and convincing evidence" of a . . . legislative intent' to restrict access to judicial review." With respect to the latter, the Court stated that agency action is committed to agency discretion where "'statutes are drawn in such terms that in a given case there is no law to apply.'" *Id.* The Court analyzed the statutes in question under each of these standards separately before concluding in *Overton Park* that the challenged action was subject to judicial review. In the present case the Court below followed precisely the same analysis. It first found that judicial review was not precluded by statute under § 701(a)(1) because there was no clear and convincing evidence of a legislative intent to preclude it. However, the Court properly went on to hold that the timing of interim Medicare payments was committed to agency discretion within the meaning of § 701(a)(2) because there was no law to apply (317a-19a).

There is nothing in the Court's earlier opinion in *Data Processing* which in any way conflicts with the dual standard analysis of *Overton Park*. The language upon which plaintiffs-intervenors place such heavy reliance is quoted in passing from the House Report for the proposition that the review provisions of the APA should be liberally construed; since the Court found *no* evidence of an intent to preclude judicial review, the standard of "clear and convincing evidence" is pure dictum. 397 U.S. at 156-67. Furthermore, although the opinion quotes in full both of the exceptions of § 701(a), it does not appear to have given any consideration to the "com-

mitted to agency discretion" exception, since the issue of whether there was law to apply was never raised.* The standard mentioned in *Data Processing*, therefore, can hardly be said to govern a case such as this one which, like *Overton Park*, does involve that issue. Indeed, as Professor Davis has pointed out, there are many decisions, such as this Court's in *Kletschka* v. *Driver*, *supra*, in which agency action has been held unreviewable in the absence of a clear and convincing showing of legislative intent. Unless that standard is read as only one of a number of possible reasons for denying judicial review, "[a] flat assertion that the dictum in *Data Processing* is not the law is not too strong." Davis, Administrative Law Treatise § 28.08 at 947 (1970 Supp.). See also Saferstein, *supra*.

Finally, plaintiffs-appellants argue that there is "law to apply" here which the Court below overlooked.** On the one hand, plaintiffs-appellants contend that the Court

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* In discussing reviewability, the Court stated that the only question was whether judicial review of the challenged action had been "precluded" and went on to hold that there was no evidence that the statutes in question sought to preclude it. *Id.* at 156-57. This language seems to indicate that the Court was concerned only with the "precluded by statute" exception. Furthermore, it is noteworthy that none of the briefs and neither of the lower court opinions raised the issue of reviewability or even cited 5 U.S.C. § 701(a). The Court's discussion of this issue would thus appear to be secondary to its holding on the standing question.

** Plaintiffs-appellants also argued below that the new PIP system violated the provisions of 20 C.F.R. § 405.454(b). The Government's witness, Mr. Jansak, testified that this regulation concerned the processing of bills under the conventional reimbursement method and has no relevance to a periodic interim payment system (234a-37a; 266a-68a). The Court below held that "this regulation is not a standard applicable to the regulation under attack here" (320a). Neither plaintiffs-appellants nor intervenor plaintiffs-appellants challenge that holding on this appeal.

below should have viewed the overall purpose of the Medicare Act to determine whether the challenged agency action conforms to that purpose. The difficulty with this position is that if a general statement of statutory purpose can provide the "law to apply," nothing would remain of the "committed to agency discretion" exception to judicial review. Although there is some language in the legislative history to this effect, as one scholar has noted, "[m]any of the committee members confused non-reviewability with scope of review" and "[m]any of the statements supporting [this] contention seem to have been overstatements made in response to questions by members who mistakenly believed the doctrine immunized all agency action involving discretion." Saferstein, *supra* at 374 and n. 33. The Supreme Court in *Overton Park* made clear that this exception has continuing validity and that where there is "no law to apply," agency action cannot be reviewed for abuse of discretion. This doctrine cannot be evaded by reliance on the standard statutory provision authorizing the Secretary to promulgate "such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which [he] is charged under this chapter." 42 U.S.C. § 1302.* As the Ninth Circuit held in *East Oakland-Fruitvale Planning Council* v. *Rumsfeld*, *supra*, 471 F.2d at 532, such a generalized rule making provision cannot provide the basis for judicial review that an agency action is arbitrary, capricious, and an abuse of discretion. This is especially so

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* This provision governs the rule making authority of the Secretary of the Treasury and the Secretary of Labor, as well as the Secretary of Health, Education, and Welfare as to *all* Social Security programs under chapter 7, 42 U.S.C. §§ 301 *et seq.* With respect to the Medicare program in particular, the rule making authority of the Secretary of Health, Education, and Welfare is governed by 42 U.S.C. § 1395hh.

where, as here, the subject matter of the challenged regulation, the timing of interim payments, is specifically governed by another statutory provision, 42 U.S.C. § 1395g, that is even broader in its grant of discretion.

On the other hand, plaintiffs-appellants maintain that there is "law to apply" in this case in that the validity of the challenged regulation must be evaluated in light of two provisions of the Medicare Act and the regulations promulgated thereunder which (1) require that hospitals be reimbursed the reasonable costs of providing services and (2) prohibit the shifting the costs of Medicare beneficiaries to non-Medicare patients. In response to this contention below, defendants-appellees agreed that the District Court had jurisdiction to decide this issue of alleged statutory violations pursuant to 28 U.S.C. § 1361,* and the Court did not hold to the contrary.**

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* In attempting to prevent an alleged violation of a statutory duty, plaintiffs-appellants appear to be seeking a writ of mandamus. In applying the remedy of mandamus, "there is a recognizable difference . . . between cases '[w]here the matter is peradventure clear, where the agency is clearly derelict in failing to act, where the inaction or action turns on a mistake of law,' on the one hand, and, on the other, those 'where the duty to act turns on matters of doubtful or highly debatable inferences from large or loose statutory terms' . . . and 'the very construction of the statute is a distinct and profound exercise of discretion.'" *Kahane* v. *Carlson*, — F.2d —, Docket No. 75-2088 (2d Cir., November 26, 1975) slip. op. at 725 (Friendly, *J.*, concurring), quoting from *Panama Canal Co.* v. *Grace Line Co., Inc.*, 356 U.S. 309, 318 (1958). The instant case clearly appears to fall in the latter category. Thus, plaintiffs-appellants' claim for relief in the nature of mandamus must be supported by an especially clear showing that the challenged regulation violates a duty imposed by the statute and regulations.

** With respect to the alleged violation of the prohibition against shifting Medicare costs to non-Medicare patients, the Court below noted that the challenged regulation did not deal with the problem of reimbursement and held that this issue was not ripe for judicial review (322a).

It does not follow, however, that the regulation in question may also be reviewed as arbitrary, capricious, and an abuse of discretion. On the contrary, this Court recognized in *Kletschka* v. *Driver*, *supra*, 411 F.2d at 444, that agency action is unreviewable "to the extent" it is committed to agency discretion; thus, such action may be reviewable as violative of a statutory right, yet at the same time unreviewable as an abuse of discretion.* Similarly, in the instance case, once the Court has determined that the challenged regulation does not conflict with any statutory provisions (see Point II *infra*), its task is completed. The statute gives complete discretion to the Secretary to decide when interim Medicare payments are to be made, so long as they are made at least monthly. Since there is therefore no standard by which the Court can determine whether that decision is arbitrary, capricious, and an abuse of discretion, the reasons for that decision and the facts underlying these reasons are unreviewable.

POINT II

The challenged regulation is clearly within the authority delegated to the Secretary and does not violate the reimbursement principles of the Medicare Act.

As demonstrated in Point I *supra*, the Secretary has unreviewable discretion pursuant to 42 U.S.C. § 1395g to promulgate regulations establishing an interim payment system so long as payments are made at least once a month. The new PIP system contained in the challenged regulation provides for bi-weekly interim payments to be made two weeks after the end of the service period to which they apply. It is therefore clearly within the authority delegated to the Secretary by the Act. Plaintiffs-appellants contend nevertheless that the new PIP system would violate two reimbursement principles contained in the Medicare Act. This contention is utterly devoid of merit.

* In *Kletschka* this Court considered whether the denial of research grant was a violation of a veteran's reemployment rights under 50 U.S.C. App. § 459(b)(A)(i), even though it held that the merits of such a decision was "committed to agency discretion by law."

First, plaintiffs-appellants argue that the new PIP system violates the statutory requirement that providers be reimbursed the "reasonable cost" of services to Medicare beneficiaries. 42 U.S.C. §§ 1395f(b) and 1395x(v)(1)(A). Their rationale for this conclusion is that "working capital" must be considered an element of "reasonable cost" and that the new PIP system, by increasing the time between the delivery of a service and reimbursement, fails to provide for working capital. Plaintiffs-appellants cite no authority for this proposition. Instead, they (1) rely on the self-serving statements of their witnesses; (2) cite the fact that Medicaid and Blue Cross deposit funds with New York area hospitals to meet working capital needs; and (3) point out that two former Medicare regulations, not in issue here, and the old PIP system, with its payments in advance of expenditures,* were more advantageous to the hospitals' cash flow position than the new PIP system. Obviously none of these arguments are germane to the claim that the new PIP system conflicts with the reimbursement requirements of the Act.

* In Point III of their Brief, plaintiffs-appellants argue that there is no support in the record for the Government's claim that under the old PIP system, hospitals were being paid before they had actually expended their funds for services and goods. However, if this is so, it makes no sense to claim, as they do in Point II of their Brief, that the old PIP system provides for working capital. Plaintiffs-appellants cannot have it both ways.

In fact, no such conflict exists. In the first place, the Medicare Act quite clearly distinguishes between the principles of reimbursement and the method by which interim payments are to be made. Where § 1395g deals only with the latter issue, § 1395x(v)(1)(A) deals exclusively with the former, defining "reasonable cost" so as to provide principles for determining the amount of reimbursement. See 20 C.F.R. § 405.402(b). Thus, there is nothing in the challenged regulation as to the timing of interim payments which could violate § 1395x(v)(1)(A). Moreover, that section defines "reasonable cost" as a cost "actually incurred." Thus, as Mr. Jansak testified, "working capital" is not reimbursable under Medicare as a "reasonable cost" of providing services unless and until a cost is incurred in the form of interest on a loan to obtaining working capital (223a-24a).* Since such interest expenses continue to be reimbursable under the new PIP system on the same terms as heretofore, there is no conflict between that system and the reimbursement principles of § 1395x(v)(1)(A).

Second, plaintiffs-appellants contend that the new PIP system violates the prohibition against imposing the necessary costs of efficiently delivering covered services from individuals covered by Medicare to individuals not

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* Mr. Jansak's testimony on this question is not merely the opinion of an expert with considerable experience in this field. It also reflects the agency's interpretation of the statutory scheme as embodied in the challenged regulation. The rule is therefore applicable here that:

> "Given the deference normally accorded an administrator's interpretation of the statutory scheme he carries out, those who attack that interpretation necessarily shoulder a heavy burden."

Johnson's Professional Nursing Home v. *Weinberger*, 490 F.2d 841, 844 (5th Cir. 1974). See also *Connecticut State Department of Public Welfare* v. *Department of Health, Education, and Welfare*, 448 F.2d 209, 213 (2d Cir. 1971).

so covered. 42 U.S.C. § 1395x(v)(1)(A). The basis for this position is the alleged fact that because of the cash flow problem of the New York area hospitals, the change in the PIP system will necessitate the borrowing of money to meet current expenses and that the interest on such loans will be only partly reimbursed under Medicare. The Court below, noting that the challenged regulation does not deal with this problem, held that this question "must await the determination of the amount of reimbursement" (322a). This holding was clearly correct. As the Supreme Court declared in *Abbott Laboratories, Inc.* v. *Gardner*, 387 U.S. 136, 148-49 (1967):

> "Without undertaking to survey the intricacies of the ripeness doctrine it is fair to say that its basic rationale is to prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also to protect the agencies from judicial interference until an administrative decision has been formalized and its effects felt in a concrete way by challenging parties. The problem is best seen in a twofold aspect, requiring us to evaluate both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration."

The Medicare Act and the regulations promulgated thereunder provide a detailed administrative procedure for the determination of the proper amount of reimbursement, at the end of which there is a right to judicial review. See 42 U.S.C. §§ 1395g and 1395oo and 20 C.F.R., Subpart R, §§ 405.1801 *et seq.* Plaintiffs-appellants have not yet even begun that procedure, much less obtained a final determination as to the amount of reimbursement for interest expenses they are entitled to receive.* Thus, the

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* Indeed, plaintiffs-appellants have not yet even incurred the interest expenses for which they claim they are entitled to reimbursement, and they vigorously argue that some hospitals will not be able to obtain loans for working capital. The entire issue is thus abstract in the extreme.

agency has not yet had any opportunity to develop the necessary factual record and apply its expertise to the interpretation and application of the principles of reimbursement contained in the Medicare Act and regulations.* Cf. *McKart* v. *United States*, 395 U.S. 185, 193 (1969). Moreover, since the challenged regulation does not deal with the question of the amount of reimbursement but only with the timing of interim payments, the appropriate remedy to seek is not an injunction against the implementation of the new PIP system, but rather a grant of reimbursement to the hospitals for 100% of the interest expenses occasioned by the challenged regulation. Such relief can only occur, however, after interest expenses have actually been incurred and reimbursement has been sought. Judicial consideration of this issue is therefore clearly premature and would unduly interfere with the administrative process. See *Gardner* v. *Toilet Goods Association, Inc.*, 387 U.S. 167 (1967).

In any event, even if it is assumed that plaintiffs-appellants will not be reimbursed for 100% of their interest expenses occasioned by the change in the PIP system, there is no violation of the principle set forth in 42 U.S.C. § 1395x(v)(1)(A) that the cost of providing services to Medicare beneficiaries will not be borne by non-Medicare patients. The interest expense that would be incurred to obtain working capital would not be a cost of delivering covered services only to Medicare patients. Rather, as Mr. Birnbaum, Deputy Director for Fiscal Affairs at Montefiore Hospital, testified, it would be a general operating expense, necessary to meet payrolls and pay vendors and thus to provide *all* services to *every* patient (135a). The

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* Plaintiffs-appellants point to the language of the relevant regulations and the testimony of Mr. Jansak (270a) to support their contention that the hospitals will not be reimbursed the full amount of their interest expenses on borrowing occasioned by the change in the PIP system. Even if that contention is correct, the responsibility for making the determination as to the correct amount of reimbursement rests with the agency itself.

fact that the particular need to borrow such funds might be precipated by the change in the PIP system * is irrelevant. As long as an interest expense on current indebtedness is necessary and proper, it is reimbursable under Medicare whatever the immediate cause or precipating event of the cash shortage. 20 C.F.R. § 405.419. Thus, as every one of plaintiffs-appellants' witnesses admitted, hospitals have in the past been reimbursed by Medicare for their necessary and proper interest costs necessitated by problems unrelated to the Medicare payment system (84a; 122a-23a; 160a; 175a). This fact was corroborated by the Government's expert, Mr. Jansak, who went on to explain that the reason for this lies in the fundamental nature of the Medicare program under which Medicare pays its share of total operating expenses, such as interest on loans, rather than isolate each separate item and analyze its cause (218a-21a; 244a-46a; 268a-70a). Thus, Mr. Jansak concluded that in reimbursing only the Medicare percentage, rather than all, of the cost of borrowing that would be necessitated by the change in the PIP system, the agency would not be transgressing the prohibition in 42 U.S.C. § 1395x(v)(1)(A) against shifting to non-Medicare patients the cost of providing services to Medicare patients. As Mr. Jansak explained, that provision of § 1395x(v)(1)(A) relates to the method of apportionment of costs and serves to prevent non-Medicare patients from paying for a higher percentage of the cost of a class of services than they actually use; that is, it serves to ensure that Medicare pays its fair share of the *total* institutional cost.** How-

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* As the record makes clear, the hospitals' cash flow problem and their need to borrow money to obtain working capital are caused by numerous factors quite independent from the Medicare reimbursement system (60a-61a; 76a-77a; 129a-30a; 146a; 179a).

** See 20 C.F.R. § 405.402(b) which restates the general policy that "the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients."

ever, where, as here, a cost may be incurred to provide services to all patients, Medicare would be obligated to pay only its normal portion of that cost, regardless of the event which made the cost necessary (221a-23a).

POINT III

The challenged regulation is a valid exercise of the Secretary's discretion and is not arbitrary, capricious, and an abuse of discretion.

The Court below did not reach the contention of plaintiffs-appellants that the regulation implementing the new PIP system is arbitrary, capricious, and an abuse of discretion, since it held that the Secretary's decision to promulgate that regulation was not subject to judicial review.* For the reasons set forth in Point I *supra*, that decision should be affirmed. However, if reviewable, the challenged regulation must be upheld as a rational exercise of the Secretary's broad discretion under 42 U.S.C. § 1395g.

In applying the "arbitrary and capricious" standard of 5 U.S.C. § 706(2)(A), the Supreme Court has said:

> "To make this finding the court must consider whether the decision was based on a consideration

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* The only discussion of the merits of the new PIP system contained in the District Court's opinion was in connection with its rejection of the claim below (abandoned on this appeal) that there had been an inadequate statement of reasons for the change in payment system (321a). It is therefore disingenuous, to say the least, for plaintiffs-appellants to state on p. 35 of their Brief that the Court's "reasoning seems to be that administrative action can be sustained on a mere statement of reasons without any examination as to their adequacy or support in the administrative record." Indeed, throughout Point III of their Brief, plaintiffs-appellants accuse the District Court of making findings on this issue based on insufficient evidence when in fact no such findings were made.

> of the relevant factors and whether there has been a clear error of judgment . . . [citations omitted]. Although this inquiry into the facts is to be searching and careful, the ultimate standard is a narrow one. *The court is not empowered to substitute its judgment for that of the agency.*" (emphasis added)

Citizens to Preserve Overton Park v. *Volpe, supra,* 401 U.S. at 416. Furthermore, in rulemaking, where regulations must be upheld unless they are arbitrary and capricious, the Second Circuit has said that it is "sufficient that the regulations be supported by evidence in the [Secretary's] files, or even by [his] experience." *Consumers Union of United States* v. *Consumer Product Safety Commission,* 491 F.2d 810, 812 (2d Cir. 1974).

The testimony of Mr. Jansak completely negates the claim that the challenged regulation is arbitrary, capricious, and an abuse of discretion, and demonstrates rather that it was the product of long and careful study and was based on reasonable policy considerations supported by concrete factual data and years of experience.

During the first two years of the Medicare program, there developed a serious backlog in interim payments under the conventional reimbursement system, and the old PIP system was therefore initiated to provide greater regularity in payments and thus a greater predictability in cash flow for the hospitals (195a-96a). Between January 1, 1968 and January 1, 1973 approximately 800 hospitals out of the 6,700 hospitals in the country participating in Medicare switched to old PIP (197a). By 1973 the Medicare program had stabilized, and the intermediaries were billing more efficiently (257a). The Secretary therefore put a moratorium on new hospitals switching to the old PIP system in order to undertake a reexamination of that system (200a).

A major reason for this reexamination was a concern that the weekly payment cycle was substantially faster than under the conventional reimbursement system (201a). This fact was apparent to the Secretary from studies which are prepared on a regular basis in the course of the billing preparation and payment process (202a). According to these studies the average lag between the time a service is delivered and the time payment is made was 30 days under the conventional system and only 3½ days under old PIP (202a-05a). This meant that there was a substantial cash flow advantage to hospitals on the old PIP system which seemed inappropriate (206a). Moreover, such a rapid periodic interim payment also seemed unnecessary in view of the fact that the hospitals themselves did not have to make payments to their employees and vendors within such a short time after the delivery of goods or services (207a).* Finally, it was obvious to the Secretary that by making payments so rapidly to hospitals under the PIP system, the Government was losing interest on those funds, and that old PIP therefore created a drain on the Medicare Hospital Trust Fund (207a). As a result of this reexamination, the Secretary lifted the moratorium on the periodic interim payment system in September 1973 but required that new hospitals wishing to use that system would be paid bi-weekly with a two week lag after the end of the period for which payment was made (208a-09a).

Thereafter, in January 1974, a Notice of Proposed Rulemaking was issued (212a-13a). Pursuant thereto about 70 comments were received, mostly from organi-

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* It is noteworthy that the testimony of plaintiffs-appellants' witnesses corroborated the experience of the agency that payrolls and fringe benefits are generally paid on a bi-weekly basis and that vendors are often not paid until 60 days or more after goods are delivered (93a-94a; 131a-33a; 137a; 148a; 156a; 170a-71a).

zations of hospitals and individual hospitals, and they were generally critical of the proposed change in payment schedule under PIP (213a-14a). These comments were given careful consideration by the Secretary (214a). Nevertheless, it was decided that the hospital's objections based on their cash flow problems were outweighed by the factors favoring the modification of the PIP system: more consistency between the payment lags under conventional reimbursement and PIP; reimbursement more closely related to the date hospitals make their payments rather than the date the medical services are rendered to patients; and an end to the unnecessary loss of interest from the Federal Hospital Insurance Trust Fund. In this way the predictability feature of the PIP system would be preserved without the disadvantages of a weekly payment schedule (215a-18a).

It is understandable that plaintiffs-appellants should oppose this modification of the PIP system, for a payment lag of 3½ days is obviously more advantageous to them than one of 3 weeks. However, they have failed to adduce any evidence or present any legal argument to show that this change is so irrational as to be arbitrary, capricious, and an abuse of the wide discretion delegated to the Secretary under 42 U.S.C. § 1395g.

First, plaintiffs-appellants maintain that the differential between payment lags under the conventional reimbursement system and those under old PIP is not a valid reason for the change to new PIP (1) because the difference between the two systems must have been apparent from the beginning of old PIP in 1968; (2) because the payment lag under the new PIP system is still somewhat shorter than under conventional reimbursement; and (3) because the changeover disregards the unique problems of the New York area hospitals. However, the new PIP system was promulgated not because

of a formal inconsistency between old PIP and conventional reimbursement, but because of the way these systems worked out in practice. As Mr. Jansak testified, the agency's change in thinking about the PIP system was caused by its experience with the two systems, for conventional reimbursement had improved significantly since 1968 while weekly PIP had proved to be a greater drain on the payment process than had originally been anticipated (206a-07a). The challenged regulation was then promulgated to bring the periodic interim payment system into closer line with the conventional reimbursement system under which the vast majority of the nation's hospitals participating in Medicare were paid; the purpose was not to make the payment lags identical. And even if it is true that the New York area hospitals are in a different position from hospitals elsewhere,* the Secretary is not required to take into account every variation in circumstance in promulgating a regulation. So long as that regulation is of a generalized nature, the fact that its effects may be more disadvantageous to some hospitals than to others does not influence its validity. See *United States* v. *Florida East Coast Railway Co.*, 410 U.S. 224, 246 (1973). As Mr. Jansak testified, Medicare is a national program with one unified reimbursement system for the entire country; although the problems of localities and individual hospitals are considered, the regulations concerning interim payment are uniform (252a-54a).

Second, plaintiffs-appellants contend that the length of time that a hospital takes to pay its vendors is irrelevant to the reasonableness of the interim payment system, since hospitals should be paid for their services without regard to when they make their expenditures. This argument misconceives the nature of the whole Medicare re-

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* Plaintiffs-appellants fail to cite any evidence in the record to support this contention on pp. 37-38 of their Brief.

imbursement system, for payments are made not for services furnished by the hospital to Medicare patients, but rather for costs "actually incurred" by the hospitals. 42 U.S.C. § 1395x(v)(1)(A). Thus, an interim payment system is properly directed toward the timing of the hospitals' expenditures rather than the delivery of medical services, which, as shown above, was precisely one of the bases for the promulgation of new PIP.

Third, plaintiffs-appellants claim that there is insufficient support in the record for the conclusion that the implementation of the new PIP system will generate greater interest for the Federal Hospital Insurance Trust Fund. In particular, plaintiffs-appellants decry the absence of data as to a possible increased drain on the Trust Fund due to interest expenses and higher vendor prices that might result from the changeover to the new PIP system. However, the Secretary is not required to gather and analyze such wide-ranging data where common sense and experience suffice. In the first place, plaintiffs-appellants' argument is based on the assumption that Medicare will reimburse the hospitals for 100% of such increases in interest expenses and costs of goods. However, if, as plaintiffs-appellants maintain in Point II of their Brief, reimbursement will be made only for the normal Medicare percentage of such costs, there must be a net gain to the Trust Fund. Moreover, it is unrealistic to assume, as plaintiffs-appellants apparently do, that every dollar in lost cash flow will generate a dollar in borrowing among hospitals on the old PIP system or a dollar in increased vendor prices. Not every one of the 800 hospitals in the country on the old PIP system has to borrow money or further delay payments to vendors to make up for the loss of cash flow, and not every vendor will necessarily raise his prices in response to every such

increased delay.* Furthermore, the benefit to the Trust Fund is not limited to three-weeks' worth of interim payments, but also includes continual interest on that sum in perpetuity. This gain in interest must offset any temporary increases in interest expenses and vendor prices caused by the transition.

Finally, plaintiffs-appellants argue at great length in Point IV of their Brief that the hospitals on old PIP will suffer "irreparable injury" unless an injunction is granted. To the extent that this argument implies that the Secretary gave insufficient weight to this factor in promulgating the challenged regulation,** several facts must be kept in mind. First, the anticipated loss of cash flow represents only a small fraction of the yearly Medicare payments received by the New York area hospitals (83a). Second, nationwide only about 800 hospitals participating in Medicare are presently on the old PIP system. The vast majority of the hospitals are paid under either conventional reimbursement or the new PIP system with comparable payment lags of approximately three to four weeks (197a-206a; 210a).

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* Indeed, even among the hospitals represented by plaintiffs-appellants, there is the possibility of adjusting to the loss of cash flow by making changes in the payment of fringe benefits and by passing some of the delay in receiving interim payments on to certain of their employees (147a; 170a; 150a). Similarly, the response of vendors to further delays in payments will depend on a number of factors, including how great are the present lags between the delivery of goods and payment; the record indicates that there is considerable variation among the hospitals as to the extent of such lags (131a-33a; 156a; 170a-71a; 180a).

** While a showing of injury is a traditional prerequisite for final injunctive relief, the argument contained in Point IV of plaintiffs-appellants' Brief can have no other effect on the merits of this case. Obviously, no showing of injury can entitle plaintiffs-appellants to the relief they seek where the challenged regulation is a valid exercise of the Secretary's discretion.

These hospitals have apparently managed to operate with such lags. Third, there is nothing inherent in the new PIP system that is harmful to any hospital; although the transition may cause some difficulty, once it is completed, there is no continuing injury to the hospitals formerly on old PIP (125a-26a). It was precisely to meet this problem that the Secretary delayed the effective date of the new regulation and created a six-month transition period, thereby permitting the hospitals to adjust gradually to the loss of cash flow (282a-87a).

Thus, plaintiffs-appellants have failed to demonstrate that the Secretary's decision to promulgate the challenged regulation ignored "relevant factors" or was "a clear error of judgment" and was therefore arbitrary, capricious, and an abuse of discretion. *Citizens to Preserve Overton Park, Inc.* v. *Volpe, supra*, 401 U.S. at 416. On the contrary, the administrative record demonstrates that the Secretary's decision to promulgate the challenged regulation was reasonable, well-considered, and clearly within his discretion under the Medicare Act.

CONCLUSION

For the foregoing reasons, the Order of the District Court dismissing the complaint should be affirmed.

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Respectfully submitted,

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